Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005059	A. BUILDING _____ B. WING _____	11/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTE REGIONAL HEALTH SYSTEM	1941 VIRGINIA AVE CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of a State complaint. Complaint: IN00088758 Unsubstantiated, lack of sufficient evidence. Date of Survey: 11-15-11 Facility number: 005059 Surveyor: John Lee, R.N. Public Health Nurse Surveyor Fayette Regional Health System is in compliance with 410 IAC 15-1.5-4, Medical Staff, 410 IAC 15-1.5-5, Nursing Services, and 410 IAC 15-1.6-2, Emergency Services, Hospital Licensure Rules. QA: claughlin 11/17/11	S 000		

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TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE